Authorization For Release of Medical Information

Just Kids RI Sick Care

Patient Information:

Patient Name: ______________________________

Date of Birth: ______________________________

I hereby authorize Just Kids Sick Care to release my medical records to my current pediatrician for continuity of care.

Release to:

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Information requested:

_____ All visit notes
_____ Laboratory tests
_____ X ray results
_____ Other

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I understand that this information is for use by the recipient named above only. It cannot by given to any other individuals or agency without my signed consent. This authorization will expire in 90 days from the signature date and can by revoked by me at any time. I have a right to receive a copy of this authorization.
I understand that information disclosed may contain matter that is protected by Federal and State laws, including information which my be related to ALCOHOL, DRUG, PSYCHIATRIC TREATMENT, AIDS AND/OR HIV TESTING AND/OR OTHER SEXUALLY TRANSMITTED DISEASE.
I understand this information will be released unless I specifically request that it be withheld.

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Signature of Patient/Guardian
Date

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Relationship